MEDICAL PRACTICE

Contemporary Themes

Dead children from problem families in NE Wiltshire

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Abstract

Analysis of 147 families in NE Wiltshire known to have suffered child neglect or abuse over two generations showed than in 21 years 560 children had been born. Of these, 513 were known to have been neglected or assaulted or both; 41 out of 560 had died. Only three deaths led to criminal convictions. Detailed collated confidential information indicated that parental behaviour towards the dead children, in particular those aged from 5 weeks to 1 year, had often caused or contributed to their deaths, including some claimed to be clear-cut cases of accident or illness.

Introduction

Criminal prosecutions for murder or manslaughter of children by their parents always make headlines, but such cases are relatively rare. In fact, I believe, many more small children are killed by their parents than these figures suggest, and many more are permanently crippled.

Since NE Wiltshire was the first part of Britain to start child-maltreatment registers, and has for over 25 years linked information from multiple sources, I have had unique opportunities to look at child abuse on a long time scale.

In an attempt to discover the incidence of death in childhood in problem families I have collected and collated the data on a "hard core" of such families with at least two generations of maltreated children.

Families and methods

The population of NE Wiltshire has grown from 173 000 in 1961 to over 215 000 in 1981, with Swindon enlarging and engulfing rural villages. In 1971 the population was 200 000 with 45 000 children under 12 years (18 500 children under 5 years); there were 3600 births a year. In 1971 about 40% of the population was urban. All the families studied were in the Swindon health district, comprising Thamesdown (Swindon) in the north and Kennet (Marlborough and Pewsey) in the south.

The families were stringently defined. Firstly, all required two local children (with shared parent(s)) born between 1960 and 1980 who had been neglected or maltreated at home *and* (unless killed) had received intervention by child protection agencies to prevent them from further maltreatment.

Secondly, all these children had a mother or father (living with them for three months at least) who had been neglected or maltreated in childhood and had received intervention by child protection agencies. At least three individuals from the two generations must each have been the recipients of multi-agency support—defined as three or more social support agencies or five or more agencies providing a measure of social support or control.[1]

Results

By July 1981 147 families fulfilled the criteria. They came from only 108 kindreds, since many of the children were related as first cousins, half-siblings, or half-first cousins. The 147 mothers had had 138 husbands or other partners who remained with them for long enough to be recognised as the men of the household by the various social agencies. Nine women remained single. The 147 women had 63 further husbands and 151 further cohabitees, making 214 extra male partners (352 in all) during 21 years.

By July 1981 the 147 mothers had had 619 children, making an average of 4·2 children each; the number has since risen and is still rising. Of these 619, only 560 were born between 1960 and 1980. The average age of the mothers by July 1981 was 35·2 years, and of the surviving children 12·0 years.

MALTREATED CHILDREN

Of the 560 children, 513 had suffered maltreatment ranging from episodic neglect and excessive beatings causing surface injuries through more serious cruelty to very serious physical and emotional damage. Some children were rendered brain-damaged, epileptic, subnormal, or severely subnormal in intelligence (violence-induced handicap).[3–5]

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The favoured term "non-accidental injury" is a restrictive euphemism, which fails to encompass a whole range of maltreatments, such as psychological cruelty, neglect, "failure to thrive" (for non-medical reasons or child starvation), and much else. Most crucial to this paper, non-accidental injury is a term that excludes forms of cruelty or assault that leave no obvious injury. At least 34 of the 513 children had been subjected to suffocatory techniques, such as being held under bath or lavatory water, throttling, suffering adult hands or pillows over crying faces, or even polyethylene bags used punitively or impulsively by parents. Also, many babies had been surreptitiously and violently shaken, sometimes to the point of brain damage or causing inhalation of vomit.

DEAD CHILDREN

At least 41 children out of the 560 born between 1960 and 1980 died within this period. Further children from these families died both before 1960 and in 1981, but they are excluded from the analysis since the deaths are outside the reference period. In three cases the parents were convicted of manslaughter or infanticide. Ten of those who died were index children, two of which led to convictions for infanticide. The child whose death resulted in a verdict of manslaughter was the sibling of the index children for that particular family. The table presents the age-specific death rates for the study group. All 41 children died before their eighth birthday, giving rise to an average mortality rate for the first eight years of life of 9·5 per 1000 live births. Nearly two-thirds of these children died between the fifth week and first birthday, the time interval generally recognised as that in which baby battering occurs. The death rate for this particular group of children was an alarming 47·1 per 1000 live births. To produce an estimate of the expected number of postneonatal deaths, all mothers in the study group were assumed to belong to social class V, defined according to the Registrar General's classification of occupation. Data from the Oxford Record Linkage Study for Oxfordshire were used to provide a standard rate. There were 26 observed postneonatal deaths compared with 6·3 expected. In other words, the risk of death in this group was over four times that expected (compare Roberts *et al*, 1980[2]).

CAUSES OF DEATH

Asphyxia or inhalation of gastric contents or both were the official (death certificate) primary causes of death for *11* out of the 26 deaths in the age group 5 weeks to 1 year, and for two other deaths. Asphyxia or inhalation of gastric contents was the sole cause of death (three cases) or "accident" or "death by misadventure" was given as a secondary cause (four cases).

Unofficial information from professional sources stated that one baby was "smothered ... often hit ... suffocated" by the mother. The second baby was underweight with severe nappy rash. Both babies were pallid, rejected, and fathered by faithless cohabitees. The third baby had been repeatedly thrown around by three or more violent, quarrelling adults; the infant inhaled vomit and died. The fourth had been "poorly fed and subjected to cold" before death. The fifth had suffered repeated surreptitious constrictions of breathing by the mother and intentionally held so as to inhale her own vomit ("choked to death ... criminal neglect"). The sixth had been previously battered, had nappy rash and recent bruising to the head, and died from inhaled vomit. The seventh was well nourished but had minor bruises on the face and head.

Of the remainder, in one case the coroner stated that the "baby died after life of squalor" aged 6 months; the parents were later sentenced for neglecting the surviving child. Information to the health visitor, psychiatrist, and other professionals was that the baby was suffocated by the mother. In another case—asphyxia due to proved infanticide —the baby, aged 5 months, was bruised, battered, and malnourished. While in prison the mother attacked her next baby aged 1 week.

In three cases aged 2-9 months asphyxia or inhalation of gastric contents was associated with, or secondary to, bronchopneumonia. Two of these came from one household where they were "terrorised" by a violent cohabitee.

In one case asphyxia was due to inhaled vomit after cerebral haemorrhage due to direct violence, age 2½ years. The mother was cleared of murder but convicted of cruelty to a person under 16 years. The mother admitted killing the toddler in a rage over her perception that the child was defying her, the final hittings and shakings lasting several hours.

The final case in this group was a death from asphyxia due to epilepsy (7 years); no inquest was held. Professional information was that there were four children, two dead. The mother told the psychiatrist she had "tried to press out" her living son's eyes. There were frequent fights and beatings of the two surviving children.

Age and sex characteristics of the dead children

Age at death	Boys	Girls	Sex unknown	Total	Annual death rate per 1000 live births
1st 28 days of life	3	2	1	6	10·87
29–365 days	14	12	0	26	47·10
1 year	1	0	0	1	1·84
2 years	2	1	0	3	5·67
3 years	0	1	0	1	1·93
4 years	0	0	0	0	—
5 years	1	0	0	1	2·04
6 years	0	2	0	2	4·28
7 years	0	1	0	1	2·28
Total	21	19	1	41	Average 9·50 for the first eight years of life

CHEST AND UPPER RESPIRATORY TRACT INFECTIONS

Ten deaths were certified as due to respiratory infections. In three cases bronchopneumonia was the sole cause of death given. No inquests were held. Professional sources suggested that all three had had poor care—the 6-month-old baby, for instance, was described as "unloved, uncared for by her mother." A fourth child's death was certified as due to acute bronchitis (1½ years). Before death he had been beaten by his educationally subnormal father and secretly subjected to prolonged spells of exposure to cold by his mentally ill mother, who was starving herself.

One child died of bronchopneumonia associated with cerebral haemorrhage. The mother was convicted of infanticide. This was one of two severely battered children, and the survivor was having psychological attention for screaming and fears years later.

In three children the bronchopneumonia was associated with past brain damage and severe subnormality. No inquests were held. Professional sources said that the first child had been a victim of severe battering three and a half years previously with "? meningitis" as a complication. The second had suffered herpes encephalitis as a baby, but before this was said to have been subjected to suffocatory episodes by her mother on many occasions.

The remaining two suffered terminal chest infections as a consequence of multiple congenital defects (one case, 9 days old) and after malnutrition (2 months).

DIRECT BRAIN DAMAGE

Three deaths were due to direct brain damage. The first was a child of 2 months who died from subdural haemorrhage due to a fractured skull after being hit on the head; the father was convicted of manslaughter. This was one of three battered children whose mother colluded throughout (until the divorce).

The second case was of a 6-month-old infant who died from cerebral haemorrhage after skull fractures; there was an open verdict. The dead child also had bruising and healing rib fractures. A second child in this family had been "reduced to a nervous wreck." After giving birth to a third child (illegitimate), the mother burnt herself to death.

In the third case a baby of 2½ months died of cerebral haemorrhage. The inquest brought in an open verdict. Both parents were later found not guilty of manslaughter. Professional sources reported nine fractures of at least three different ages. The next child (at 4 months) had multiple fractures of at least three different ages, and was taken into care. The third child was removed at birth. The failed criminal convictions made protection of subsequent children very difficult.

MULTIPLE BURNS

Four children died in fires. A brother and sister aged 5 and 7 years, left on their own, died in a house fire. A toddler fell into a fire, and

social notes referred to another young child in the same family dying of scalds and burns.

OTHER CAUSES

From the 11 remaining deaths, one was due to gastroenteritis (child rejected, neglected, and repeatedly left on his own in the cold, before and during gastroenteritis. Under surveillance to go on the child abuse register). There were two "cot deaths"; in one the mother had said she would kill the child, paternity allegedly by rape, subsequently the child was found dead, while in the other the family doctor asked the police to investigate, believing with good cause that the child had been killed. Another rejected baby boy died at 5 weeks of hypothermia. Three infants were certified as dying at 1 day, 5½ months, and 7 months of microcephaly, heart disease, and neuroblastoma. The medical details on the residual four are untraced or very scant.

Six or seven further deaths occurred between 1960 and 1980 which were referred to in the files, but only one was recorded by both social and medical workers. These are not included in the table.

Discussion

Dead and discarded children disappear from record as if they had never existed. Previously abandoned or fostered children, children in care or in institutions (especially those for the mentally handicapped)—all are forgotten. In particular, dead or damaged children become erased by these mothers, especially if they were only half-siblings of surviving children. This process can even affect obstetric records, usually a reliable source of "lost" siblings and half-siblings.

For 13 years I have been immediately concerned with the care of one or more members from 76 of the 108 kindreds. As a psychiatrist I have been told personal accounts of killings or violence-induced mental handicap.[3-5] In parallel with this, the supporting information that has been collated on the 147 families includes unequivocal direct statements, as well as the more common partial or attenuated admissions. These, together with the collated independent facts, point at the very least to strong contributions by the mothers, cohabitees, and other family members towards the deaths of certain children. Detail can come from the mothers themselves, other relatives (sometimes actually present), or professional people. Neighbours and others, often said by professionals to have been "no better themselves" or actuated by malice, have often been right. They know from experience how mothers can deal with unloved babies and toddlers. The naive, trusting, or respectable professional averts his gaze, and does not always believe.

A characteristic vignette is as follows. Firstly, the baby (or toddler) is unwanted and unloved—resented paternity, excessive crying—related to mild illness, cold, or diarrhoea, or poor physical care, hunger, thirst, severe nappy rash; or social deprivation, mother not "tuned in" to, or bothered with, his social signals. The mother becomes distraught. The continuous crying has by now been pointedly and adversely commented on by neighbours. She reacts by shaking the child violently, holding a hand over his mouth, or impulsively pushing his head under the bath water. The last can be precipitated by disgust at vomit and faeces smeared everywhere, or by resentful distress over insatiable grizzling. He gets a little more ill, and cries more. One night, sleepy and passionately resentful, the mother or her cohabitee either holds a sheet over his face or pushes his head against the mattress. He chokes and dies. Necropsy shows inhalation of gastric contents; perhaps with evidence of upper respiratory or chest infection, or perhaps not.

This exceptional "inside information" may not be reflected in any paediatric or pathological finding. Alternatively, there may be a new light thrown on causes of death which had appeared to be uncomplicated "disease" or "accident" but which really had indirect social precipitants deriving from parental behaviour.

The gradation from the three legally confirmed killings to pure "biological" causes is as follows.

Blatant killings that are unrecognised by the law but are known to certain doctors, the police, or others (three "batterings," one severe neglect with violence).

Next, the child is killed by a parent actively or by neglect (six cases). No possibility of any official attribution of the cause of death to anything other than accident or illness, but collated professional evidence indicating a killing, usually also with one or more of the following: parent admits suffocating, or a previous suffocation, or both; relative or cohabitee describes the killing; child previously starved, battered, or maltreated either in the days or weeks before death, or violence-induced handicap[5] years previously, the old brain damage rendering the child susceptible to pneumonia. Past or recent, the maltreatment is related to the death.

Next, maltreatment or blatant neglect permits, hastens, or indirectly initiates the natural causes of death (four cases).

Next, tragic accidents or illnesses, but in young children poorly cared for or left unattended (12 cases).

Finally, prematurity, accidents, or illnesses may occur with no parental responsibility for the death, even if there had been maltreatment of the child or his siblings (six cases). The remaining six cases probably belong in one of the last three categories.

More effective family-linked information could help ensure better protection and happier lives for surviving children. If facts as basic as life and death of the siblings and half-siblings of a maltreated child are so easily buried and lost the protection of children currently on the child abuse registers becomes vague, arbitrary, and half-hearted.

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A patient with Darier's disease also has Hunner's ulcer (interstitial cystitis). Is there any relationship between the two? Are skin disorders with systemic manifestations commonly associated with bladder mucosal abnormalities?

Darier's disease is a genetically determined disorder of keratinisation that affects primarily the skin. Lesions of mucous membranes, such as the mouth, larynx, and rectum, have been reported but not very commonly. These are all areas where keratinisation could be expected. The nature of Hunner's ulcer (and even its validity as an entity) is somewhat in doubt. As its alternative name of interstitial cystitis implies, one would hardly expect it to be linked with a disorder of epidermal keratinisation. Probably the association is fortuitous. Nevertheless, even though it would not be the cause of interstitial cystitis, it is not impossible that the histological changes of Darier's disease could be seen in areas of squamous metaplasis within the bladder, which normally has a very different type of transitional epithelium. We are not aware that this has been reported. Because epidermis and bladder epithelium are so unlike, it is uncommon for skin and bladder mucosa to be affected in skin disorders. With such notable examples as herpes zoster, fixed drug eruptions, and amyloidosis a rather different type of mechanism is concerned.—R H CHAMPION, consultant dermatologist, R H WHITAKER, consultant urologist, and JANICE ANDERSON, consultant histopathologist, Cambridge.